STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
14. Services for individuals age 65 or older in institutions for mental diseases. c. Intermediate care facility Services	Billing time limitations: 1. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. 2. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (a) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (b) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. 3. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. 4. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. 5. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

See Page 9-2

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
Services that require Preauthorization	The Department of Human Resources will certify the recipient for financial eligibility, and the Department or its designee will certify the recipient as requiring intermediate care facility services for individuals age 65 or older in institutions for mental diseases. The Department or its designee will certify as requiring these services only those financially eligible recipients requiring the services provided in a facility that fully meets the requirements for a state license and certification to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental and physical condition requires health services that are above the level of room and board and can be made available only through institutional facilities.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
15. Intermediate Care Facilities Services	Billing time limitations: 1. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. 2. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (a) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (b) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. 3. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. 4. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. 5. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

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STATE PLAN FOR MEDICAL ASSISTANCE
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STATE OF MARYLAND

PROGRAM	LIMITATIONS

2. Bed reservations for recipients who are not on a leav of absence to visit with friends or relatives or to par ticipate in State approved therapeutic or rehabilitative programs for a maximum of 18 days in any calendar year and without any limitations on the number of da per visit.

3. Bed reservations for recipients hospitalized for an acute condition, exceeding 15 days per single hospital visit.

4. Administrative days not approved by the Department or its designee.

5. Audiology services.

6. Occupational therapy services, unless part of a specialized rehabilitative therapy services program.

7. Physical therapy services, unless part of a specialized rehabilitative therapy services program.

8. Speech therapy services.

9. Services for which payment is made directly to a provider other than the nursing facility.

10. Services by an out-of-state long-term facility unless a provider agreement is executed by the Department and the long-term care facility.

11. Services rendered to a recipient requiring Skilled Nursing Facility services unless Administrative days are applicable.

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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
Services that require Preauthorization	The Department of Human Resources will certify the recipient for financial eligibility, and the Department or its designee will certify the recipient as requiring intermediate care facility services except when Administrative days are applicable. The Department or its designee will certify as requiring intermediate care facility services only those financially eligible recipients requiring the services provided in a facility that fully meets the requirements for a state license and certification to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental and physical condition requires health services that are above the level of room and board and can be made available only through institutional facilities.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
16. Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities	Billing time limitations: 1. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. 2. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (a) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (b) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. 3. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. 4. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. 5. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
17. Nurse-Midwife	Nurse-midwife services are provided through the Physicians' Services Program, by reimbursing physicians for the services of nurse-midwives in their employ. The Program also reimburses nurse-midwives directly for medically necessary services relating to the management and complete care or normal women antepartally, interpartally, postpartally (including family planning), and normal newborn children (first 48 hours of life). Such reimbursement is subject to the limitations listed below. The following are not covered under the Nurse-Midwife Regulations: 1. Services not medically necessary. 2. Services prohibited by the Maryland Nurse Practice Act or by the State Board of Examiners of Nurses. 3. Services provided to HMO Medical Assistance enrollers. 4. Services for inpatient recipients in State-operated psychiatric, mental retardation facilities, or State chronic hospitals. 5. Visits to the nurse-midwife solely for the purpose of obtaining prescriptions, drugs, food supplements, laboratory specimens, or the interpretation of laboratory findings. 6. Drugs and supplies which are acquired at not cost. 7. Injections and visits solely for injections unless medical necessity and patient's inability to take appropriate oral medications are adequately documented. 8. More than one visit per day unless adequately documented as an emergency situation.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM (Continued)	LIMITATIONS
17. Nurse-Midwife Services	9. Repealed - effective 10-1-85 10. Acupuncture 11. Hypnosis 12. Separate visit charge on date of delivery 13. Travel expenses 14. Laboratory or radiology services performed by another facility. The facility must bill directly. 15. Specimen collections as a separate service, except venipuncture. 16. Charges for completion of forms or reports, broken or missed appointments, professional services rendered by mail or telephone, and services provided to the general public at no charge. 17. Billing time limitations: a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
(Continued) 17. Nurse-Midwife Services See Page 9-2	c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. 18. Prenatal or post-partum care once the patient has been referred to a physician for completion of care.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
18. Hospice Care	1. Hospice care shall be available to a participant for two 90-day election periods and one 30-day election period. 2. A participant must use the two 90-day election periods before using the 30-day election period. 3. At the expiration of the 30-day election period, hospice care may be continued without a break for one or more 30-day extended election periods as long as the provider obtains a written certification statement that the participant's medical prognosis is for a life expectancy of six months or less no later than two calendar days after the beginning of each 30-day extended election period. 4. An election period or an extended election period shall terminate prior to expiration when one of the following conditions is met: a. The participant dies; b. The election of hospice care is revoked; c. The participant's eligibility for Medical Assistance is cancelled; or d. The Program determines that the election period or extended election period shall be terminated for cause. 5. When a participant revokes the election of hospice care during an election period, any remaining days in that election period shall be forfeited. Thereafter, the participant may elect hospice coverage for any remaining election periods for which the participant is eligible.

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